BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **DARRELL J. JESSOP, M.D.** License No. 23441 For the Practice of Allopathic Medicine In the State of Arizona.	Case Nos. MD-07-0189A MD-07-1027A MD-08-1090A MD-09-0467A **CONSENT AGREEMENT FOR DECREE OF CENSURE, PROBATION AND PRACTICE RESTRICTION**

CONSENT AGREEMENT

By mutual agreement and understanding, between the Arizona Medical Board ("Board") and Darrell J. Jessop, M.D. ("Respondent"), the parties agree to the following disposition of this matter.

1. Respondent has read and understands this Consent Agreement and the stipulated Findings of Fact, Conclusions of Law and Order ("Consent Agreement"). Respondent acknowledges that he has the right to consult with legal counsel regarding this matter.

2. By entering into this Consent Agreement, Respondent voluntarily relinquishes any rights to a hearing or judicial review in state or federal court on the matters alleged, or to challenge this Consent Agreement in its entirety as issued by the Board, and waives any other cause of action related thereto or arising from said Consent Agreement.

3. This Consent Agreement is not effective until approved by the Board and signed by its Executive Director.

4. The Board may adopt this Consent Agreement or any part thereof. This Consent Agreement, or any part thereof, may be considered in any future disciplinary action against Respondent.

5. This Consent Agreement does not constitute a dismissal or resolution of other matters currently pending before the Board, if any, and does not constitute any waiver, express or implied, of the Board's statutory authority or jurisdiction regarding any other pending or future investigation, action or proceeding. The acceptance of this Consent Agreement does not preclude any other agency, subdivision or officer of this State from instituting other civil or criminal proceedings with respect to the conduct that is the subject of this Consent Agreement.

6. All admissions made by Respondent are solely for final disposition of this matter and any subsequent related administrative proceedings or civil litigation involving the Board and Respondent. Therefore, said admissions by Respondent are not intended or made for any other use, such as in the context of another state or federal government regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or any other state or federal court.

7. Upon signing this agreement, and returning this document (or a copy thereof) to the Board's Executive Director, Respondent may not revoke the acceptance of the Consent Agreement. Respondent may not make any modifications to the document. Any modifications to this original document are ineffective and void unless mutually approved by the parties.

8. If the Board does not adopt this Consent Agreement, Respondent will not assert as a defense that the Board's consideration of this Consent Agreement constitutes bias, prejudice, prejudgment or other similar defense.

9. This Consent Agreement, once approved and signed, is a public record that will be publicly disseminated as a formal action of the Board and will be reported to the National Practitioner Data Bank and to the Arizona Medical Board's website.

10. If any part of the Consent Agreement is later declared void or otherwise unenforceable, the remainder of the Consent Agreement in its entirety shall remain in force and effect.

11. Any violation of this Consent Agreement constitutes unprofessional conduct and may result in disciplinary action. A.R.S. §§ 32-1401(27)(r) ("[v]iolating a formal order, probation, consent agreement or stipulation issued or entered into by the board or its executive director under this chapter") and 32-1451. **The Board will immediately institute proceedings seeking revocation of Respondent's license upon violation of this Consent Agreement or further acts of unprofessional conduct.**

12. Respondent acknowledges that, pursuant to A.R.S. § 32-2533(E), he cannot act as a supervising physician for a physician assistant while his license is under probation, restriction or suspension unrelated to rehabilitation.

13. ***Respondent has read and understands the conditions of probation.***

DARRELL J. JESSOP, M.D.

DATED: 3/09/2010

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of license number 23441 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case numbers MD-07-0188A, MD-07-1027A, and MD-08-1090A after receiving a complaint regarding Respondent's care and treatment of a forty-two year-old female patient ("CM"), a forty-eight year-old female patient ("LM") and a twenty-six year-old female patient ("DO"). Subsequently, the Board initiated case number

MD-09-0467A after Board Staff conducted a pharmacy survey that demonstrated that Respondent violated a Board Order.

MD-07-0189A - PATIENT CM

4. On February 6, 2004, CM presented to Respondent for pain management. Despite no documented pain generators or diagnosis, Respondent prescribed Dilaudid and Hydrocodone and escalated her prescription for Methadone. From March 2004 through 2005, Respondent prescribed numerous escalating doses of Methadone, Oxycontin, Demerol, Oxycodone, Actiq and Hydrocodone for various complaints that included cervical degenerative disc and osteoarthritis of multiple sites. Despite magnetic resonance imaging studies and x-rays that reported mild degenerative changes, Respondent continued to prescribe escalating doses of narcotics and other controlled substances.

5. On October 16, 2006, CM presented for a follow up visit. CM reported erratic behavior and that she lost her prescriptions. Respondent ordered a urine drug screen that was positive for Methadone, which had not been prescribed to CM for at least a year. There was no indication that Respondent addressed CM's erratic behaviors or the positive drug screen.

6. On April 3, 2007, the Board notified Respondent of its investigation and requested CM's medical records. Respondent initially provided Staff with CM's medical records from February 2006 through March 2007. Subsequently, Respondent submitted the remaining medical records dated February 2004 through 2006; however, the medical records did not correspond to the initial medical records submitted by Respondent. Specifically, the diagnosis of Fibromyalgia and a documented physical exam appeared in each of the subsequent records, but not in the initial records. Additionally, the medical record dated February 6, 2004 contained the time of an open median nerve

decompression surgery CM underwent in December 19, 2005, which Respondent would not have known about in 2004, indicating Respondent created or altered the record thereafter.

7. The standard of care requires a physician to have indications of pain generators and corresponding diagnoses before continuing opioid medication and escalating doses and to assess and appropriately treat break through pain. The standard of care also requires a physician to appropriately recognize, monitor, and act on worsening function and pain, significant side effects, or red flags of drug addiction, diversion behavior, or medication misuse and to address abnormal findings on urine drug test results. Additionally, the standard of care requires a physician to safely titrate Methadone; to treat chronic non-malignant pain with medications, psychological approaches, and behavioral strategies to reduce distress; and to obtain specialist consultations as indicated.

8. Respondent deviated from the standard of care because he did not have present presumed pain generators and diagnoses for continuing opioid medication and escalating doses for the patient CM; he did not assess and appropriately treat CM's break through pain. Respondent also deviated from the standard of care because he did not appropriately monitor and recognize CM's drug addiction and diversion behavior, or medication misuse and he did not address abnormal findings on her drug test results. Additionally, Respondent deviated from the standard of care because he did not safely titrate CM's Methadone doses.

9. Respondent's inappropriate management of CM's chronic pain could have led to Methadone toxicity, overdose, brain damage and death.

MD-07-1027A - PATIENT LM

10. From March 2002 through October 2006, LM presented to Respondent with a diagnosis of rheumatoid arthritis, fibromyalgia, depression and generalized anxiety.

Respondent treated LM with escalating dosages of opioids, antidepressants, muscle relaxants, stimulants and anxiolytics. There was no indication that Respondent obtained LM's medical records, lab results or communicated with LM's rheumatologist prior to prescribing medications. At several office visits, LM reported continued severe pain, increased depression and anxiety, decreased functionality, somnolence, difficulty concentrating and poor short-term memory. Despite this, Respondent continued to prescribe escalating opioid dosages without re-evaluating LM or reviewing past medical records. Respondent also did not recognize, monitor, or act upon signs of unchanged or worsening function and pain, significant side effects or red flags of substance misuse. Additionally, Respondent allowed LM to adjust her medications and dosages.

11. On several occasions, Respondent noted that LM had continuing and escalating complaints of pain, depression and anxiety and that she needed consultations with specialists in psychiatry, pain management and rheumatology. However, there was no indication that Respondent referred LM to any specialists. On November 17, 2006, LM voluntarily admitted herself to inpatient behavioral health due to suicidal ideation. Subsequently, LM died of Oxycodone and Alprazolam overdose.

12. The standard of care requires a physician to have indications of pain generators and corresponding diagnoses before continuing opioid medication and escalating doses and to assess and appropriately treat break through pain. The standard of care also requires a physician to treat chronic non-malignant pain with medications, psychological approaches, and behavioral strategies to reduce distress; and to obtain specialist consultations as indicated.

13. Respondent deviated from the standard of care because he did not have present presumed pain generators and diagnoses for continuing opioid medication and escalating doses for LM. Respondent also deviated from the standard of care because he

did not treat LM's chronic non-malignant pain with other non-medication approaches and he did not obtain speciality consultations for her as indicated.

14. LM committed suicide and she was at high risk of accidental overdose from duplicative depressant medications and Respondent's failure to adjust medications. There was potential for LM to suffer hepatotoxicity.

MD-08-1090A - PATIENT DO

15. On February 12, 2003, DO presented to Respondent for pain management. Despite not obtaining or reviewing any past medical records, diagnostic imaging or specialist consultations, Respondent prescribed Percocet and Soma. From February 2003 through January 2007, Respondent prescribed escalating doses of Percocet, Hydromorphone, Flexeril, Baclofen, and Demerol for chronic pain. In October 2004, Respondent added Oxycodone in anticipation of dental extractions and ordered lumbar spine films. There was no indication that Respondent communicated with DO's dentist regarding the extractions and the lumbar spine films showed minimal findings. Despite this, Respondent continued to prescribe Oxycodone.

16. In July 2005, Respondent documented that DO was a high-risk patient and provided her with samples of antidepressant medication; however, he did not refer her to a mental health provider. In October 2005, Respondent obtained cervical spine x-rays that showed minimal findings and bilateral shoulder x-rays that were normal; however, Respondent continued to prescribe opioid medications for chronic pain. In September 2006, Respondent ordered a urine drug test that was negative for Oxycodone, but positive for metabolites of Valium, which was not prescribed by Respondent. There was no indication that Respondent followed up on the test results. Subsequently, DO overdosed on the prescription medications and required ventilatory support. She was later discharged without sequelae.

17. The standard of care requires a physician to obtain a patient's pain history, perform a targeted physical exam and review past medical records and diagnostic studies. The standard of care also requires a physician to appropriately recognize, monitor, and act on worsening function and pain, significant side effects, or red flags of drug addiction, diversion behavior, or medication misuse and to address abnormal findings on urine drug test results. Additionally, the standard of care requires a physician to treat chronic non-malignant pain with medications, psychological approaches, and behavioral strategies to reduce distress; and to obtain specialist consultations as indicated.

18. Respondent deviated from the standard of care because he did not have present presumed pain generators and diagnoses for continuing opioid medication and escalating doses for DO. Respondent also deviated from the standard of care because he did not appropriately monitor, recognize and act on the patients' worsening function and pain, significant side effects, red flags of drug addiction, diversion behavior, or medication misuse. Moreover, he did not address abnormal findings on drug test results for DO. Finally, Respondent deviated from the standard of care because he did not obtain specialty consultations for DO as indicated.

19. DO suffered a near-fatal overdose requiring mechanical ventilation, and hospitalization and there was potential for her to develop worsening anxiety and depression, suicide attempt or completed suicide as a result of Respondent's failure to refer her to a mental health provider. Additionally, there was potential for perpetuation of DO's substance misuse, abuse and/or addiction, by not identifying treatable etiologies of subjective complaints and for interfering with the surgeon's post-operative care and causing delay in recognizing a post-operative complication.

20. A physician is required to maintain adequate legible medical records containing, at a minimum, sufficient information to identify the patient, support the

diagnosis, justify the treatment, accurately document the results, indicate advice and cautionary warnings provided to the patient and provide sufficient information for another practitioner to assume continuity of the patient's care at any point in the course of treatment. A.R.S. § 32-1401(2). Respondent's records were inadequate because he prescribed escalated dosages of medications to DO without documented indication.

21. On June 3, 2008, Respondent was ordered to undergo a PACE evaluation and to comply with recommendations. On August 11-12, 2008, Respondent attended Phase I of PACE and it was recommended that he return for Phase II for further evaluation in a clinical setting. On November 17-21, 2008, Respondent attended Phase II of PACE and it was recommended that he provide more details in his chart notes and obtain a prescribing handbook. PACE opined that Respondent demonstrated excellent clinical knowledge of common clinical problems, but he had limited knowledge of chronic pain management.

MD-09-0467A - PATIENTS CD and AT

22. Subsequently, the Board initiated case number MD-09-0467A after Board Staff conducted a pharmacy survey that demonstrated that Respondent violated a Board Order. On June 16, 2008, Respondent entered into an Interim Consent Agreement for a Practice Restriction, which restricted him from prescribing no more than #30 short acting opioids with no refills. However, on December 15, 2008 and January 28, 2009, Respondent wrote a prescription for #60 Vicodin for patient CD. On April 7, 2009, during an investigational interview, Respondent admitted that he wrote a prescription for #60 Vicodin for patient CD on two occasions. Additionally, it was noted that Respondent also prescribed Dantrolene and administered trigger point injections to patient CD without documenting the spasticity associated with an upper motor neuron disorder. Respondent subsequently informed Staff that he prescribed Tylenol # 3 to patient AT in January 2009.

23. The standard of care requires a physician to prescribe Dantrolene in the treatment of spasticity associated with upper motor neuron disorders or for the treatment of malignant hyperthermia.

24. Respondent deviated from the standard of care because he did not prescribe Dantrolene for CD for spasticity associated with an upper motor neuron disorder or for malignant hyperthermia.

25. There was potential for patient CD to suffer hepatotoxicity and to develop central nervous system side effects, including drowsiness and confusion.

CONCLUSIONS OF LAW

1. The Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(e) ("[f]ailing or refusing to maintain adequate records on a patient."), A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public."), A.R.S. § 32-1401(27)(r) ("[v]iolating a formal order, probation, consent agreement or stipulation or entered into by the board or its executive director under the provisions of this chapter."), A.R.S. § 32-1401(27)(dd) ("[f]ailing to furnish information in a timely manner to the board or the board's investigators or representatives if legally requested by the board."), A.R.S. § 32-1401(27)(jj) ("[k]nowingly making a false or misleading statement to the board or on a form required by the board or in a written correspondence, including attachments, with the board."), and A.R.S. § 32-1401(27)(ll) ("[c]onduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient.").

ORDER

IT IS HEREBY ORDERED THAT:

1. Respondent is issued a Decree of Censure.

2. Practice Restriction

   a. Respondent is prohibited from prescribing, administering or dispensing any controlled substances for a period of **three years** (please see (c.) below).

   b. Respondent may petition the Board to terminate the practice restriction **after two years.** The Board may require any combination of staff approved physical examination, psychiatric and/or psychological evaluations, or successful passage of the Special Purpose Licensing Examination or other competency examination/evaluation or interview it finds necessary to assist it in determining Respondent's ability to safely and competently return to prescribing, administering or dispensing Controlled Substances. Respondent is responsible for all expenses related to any evaluation.

   c. This restriction does not preclude Respondent from administering controlled subetances in life-threatening emergencies.

3. Probation

Respondent is placed on probation for **three years** with the following term and condition:

   a. In the event the practice restriction is terminated in less than three years, Respondent shall employ Affiliated Monitors to conduct quarterly chart reviews for the remainder of the probationary period and report results to the Board. Respondent shall pay the expenses of Affiliated Monitors and

all chart reviews and fully cooperate with any requests made by Affiliated Monitors in conducting the chart reviews.

4. Tolling

In the event Respondent should leave Arizona to reside or practice outside the State or for any reason should Respondent stop practicing medicine in Arizona, Respondent shall notify the Executive Director in writing within ten days of departure and return or the dates of non-practice within Arizona. Non-practice is defined as any period of time exceeding thirty days during which Respondent is not engaging in the practice of medicine. Periods of temporary or permanent residence or practice outside Arizona or of non-practice within Arizona, will not apply to the reduction of the probationary period.

5. This Order is the final disposition of case numbers MD-07-0189, MD-07-1027A, MD-08-1090A, and MD-09-0467A.

DATED AND EFFECTIVE this 14TH day of April, 2010.

(SEAL)

ARIZONA MEDICAL BOARD

By: _____
Lisa S. Wynn
Executive Director

ORIGINAL of the foregoing filed this 15 day of April, 2010 with:

Arizona Medical Board
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258

EXECUTED COPY of the foregoing mailed this 15th day of April, 2010 to:

Darrell J. Jessop, M.D.
Address of Record

_____
Investigational Review
#743226